## C20

## TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT EMPLOYER'S FIRST REPORT OF WORK INJURY OR ILLNESS

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CLAIMS ADM/CARRIER	JURISDICTION CLAIM # (STATE FILE #)					CLAIM TYPE CODE  MED ONLY  INDEMNITY		The use of this form is required under the provisions of the Tennessee Workers' Compensation Law and must be completed and filed with your insurance carrier immediately after notice of injury.  It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of							
	CLAMS ADM CLAIM # (INSURER CLAIM #)					☐ BECAME LOST TIME ☐ BECAME MED ONLY ☐ NOTIFY ONLY ☐ TRANSFER									
	OSHA LOG CASE #														
	NAME OF INSURANCE CARRIER					CARRIER FEIN			committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.						
	CLAIMS ADMIN FIRM NAME (if different from carrier)					FEIN OF CLMS ADM			If you have questions, the state now has a benefit review system where a Workers' Compensation Specialist can provide assistance. Call 1-800-332-2667 (TDD).						
	CLAIMS ADJUSTER NAME					CLMS ADJ PHONE #									
	CLAIM HANDLING OFFICE ADDRESS LINE 1 AND LINE 2									CITY				ZIP	
E MPLOYER	EMPLOYER NAME					EMPLOYER FEIN			SIC CODE		PHONE NUMBER				
	EMPLOYER ADDRESS LINE 1 AND LINE 2								NATURE OF BUSINESS						
	CITY S					STATE ZIP			INSURED REPORT NUMB		BER	EMPLOYER LOCATION #		R LOCATION #	
POLICY	INSURED NAME (parent co. if different than employer)					POLIC	CY NUM	IBER	☐ FULI			_	MENT STATUS CODE . TIME/REGULAR		
						SELF	INSURI ES 🔲 N	ED? NO	EXP DATE			☐ PART TIME ☐ PIECE WORKER			
EMPLOYEE	EMPLOYEE LAST NAME					PHON	NE INCL	AREA CODE	GENDER  MALE FEMALE UNKNOWN			SEASO VOLU			
	FIRST					DEPA WOR		IT REGULARLY			_ =	=		TICE FULL TIME TICE PART TIME	
	ADRRESS LINE 1 & 2								OCCUPATION DESCRIPTION			ON			
	CITY S					STATE ZIP			MARITAL S				ARRIED PARATED	NCCI CLASS CODE	
	SSN DATE OF				BIRTH DATE OF			F HIRE	SINGLE, DIVORCED			_	KNOWN		
WAGE	WAGE PERIOD ☐ WEEKLY \$ ☐ HOURLY ☐ BI-WEEKLY				NUMBER OF DAYS WO WEEK			ORKED PER	SALARY CONTINUED IN LIEU OF COMPENSATION YES NO						
	DAILY MONTHLY								FULL WAGES PAID FOR DATE OF INJURY YES NO						
ACCIDENT/INIURY	l <u> </u>					OF INJUI ULD NO		☐ A	M ☐ PM TIME EMPLOYEE BE				EGAN WORK ON INJURY DATE  AM PM		
	DATE EMPLOYER NOTIFIED OF INJURY				BODY PART AFFECTE			ED CODE	NATURE OF INJURY				CAUSE	OF INJURY CODE	
	DATE CLAIM ADM NOTIFIED OF INJURY					How injury or illness occurred. Describe the incident including what the employee was doin the part of the body affected and how, and object or substance that directly harmed the empl							doing just before, employee.		
	DATE LAST DAY WORKED														
	DATE DISABILITY BEGAN														
	RETURN TO	TE (IF APPLICA	BLE)												
						ATH CLAIM, GIVE # DEPENDENTS FOR EACH RELATIONSHIP VIDOW						TAL # DEPENDENTS			
									AUGHTER BROTHER DN HANDICAPPED CHILD						
	ADDRESS WHERE INJURY OCCURRED (if other than employer's								STATE ZIP				COUNTY OF INJURY		
TREATMENT	PHYSICIAN NAME							HOSPITAL OR OFF SITE TREATMENT NAME							
	ADDRESS LINE 1 AND 2							ADDRESS LINE 1	AND 2						
	CITY STATE				ZIP			CITY				STATE		ZIP	
					Y EMPLOYER Y CLINIC/HOSPITAL			☐ HOSPITALIZED > 24 HRS ☐ EMERGENCY CARE			FUTURE MAJOR MEDICAL/LOST TIME ANTICIPATED				
OTHER	DATE PREPARED PREPARER' NAME & TIT							PREPARER'S COM	E	PHONE NUMBER					
i			1					1							